MINNESOTA LIFE

NOTICE OF ACCIDENTAL DISMEMBERMENT AND LOSS OF SIGHT CLAIM

Group Division Claims • P.O. Box 64114 • St. Paul, MN 55164-0114 • FOR CLAIM INFORMATION CALL: Toll Free **1 800 328-9442** - MN Local **651-665-3815**

TO BE COMPLETED BY EMPLOYER

EMPLOYER'S NAME | POLICY NUMBER

EMPLOYEE DATE OF BIRTH (MONTH, DAY, YEAR) | DATE EMPLOYED (MONTH, DAY, YEAR) | SALARY $ PER ☐ HOUR ☐ WEEK ☐ MONTH

JOB TITLE | DATE LAST ACTIVELY WORKED

STATUS ON LAST DAY WORKED
☐ FULL TIME ☐ PART TIME If part-time, average hours per week. _____

Amount of Employee's Insurance	Effective Date of Coverage
Basic $ _____	_____
Optional $ _____	_____

EMPLOYER CERTIFICATION: The undersigned certifies that above statements as to the employee are correct as reported on its records.

NAME OF EMPLOYER | EMPLOYER'S TELEPHONE NUMBER

EMPLOYER'S ADDRESS

AUTHORIZED SIGNATURE
X | DATE

CLAIMANT'S STATEMENT

To present your claim for benefits, complete this Claimant's Statement. All questions must be fully completed. Have your physician complete the Attending Physician's Statement and attach copies of your medical records. Please be sure to sign and date the authorization.

CLAIMANT'S LEGAL NAME (Last, First, Middle' Initial) | DATE OF BIRTH (Mo/Day/Yr) | SOCIAL SECURITY NUMBER

ADDRESS (Street, City, State, Zip) | TELEPHONE NUMBER ( )

DATE ACCIDENT OCCURRED | WHERE ACCIDENT OCCURRED

Did the accident result in dismemberment or total and irrecoverable loss of sight? ☐ Yes ☐ No

Please fully describe the accident.

If the dismemberment, total and irrevocable loss of sight occurred on a date later than the date of the accident, please list that date.

NAME AND ADDRESS OF PHYSICIAN TREATING YOU | TELEPHONE NUMBER ( )

NAME AND ADDRESS OF HOSPITAL | TELEPHONE NUMBER ( )

For the purpose of determining my eligibility for insurance coverage and benefits, I authorize any provider of health care, physician, medical practitioner, psychologist, chiropractor, hospital, including Veterans Administration Hospital, clinic or other health care facility, insurance company, consumer reporting agency, Social Security Administration, Internal Revenue Service, financial institutions, employer, workers' compensation, rehabilitation facility or other organization or person which has any medical or nonmedical records or knowledge, including but not limited to my physical or mental health or financial information or employment, to give all such information it has to **Minnesota Life Insurance Company** (Company) or its authorized representative. This shall include but not be limited to information regarding any medical or health history including all consultations, diagnoses, prescriptions, treatments, tests, as well as any information regarding alcohol or drug abuse, AIDS or AIDS-related conditions.

I authorize the Company to release any information relevant to my insurance coverage and claim for benefits to persons or organizations performing services related to the claim, to other insurance carriers with whom I have coverage, or to any other public or private entity as may be required.

I AUTHORIZE: Minnesota Life Insurance Company to request a report from the Medical Information Bureau (MIB), which is an association of life insurance companies that operates the Health Claim Index (HCI) for subscriber insurers. An HCI report contains the date(s) of past or present claims filed by me and the names of the companies but does not contain medical or other personal information. I understand **Minnesota Life Insurance Company** will report to MIB the dates(s) of any past or present claims filed by me.

Upon receipt of a request from me, MIB will arrange a disclosure of any information it may have in my HCI file. If I question the accuracy of information in the file, I may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB, Inc.'s information office is PO Box 105, Essex Station, Boston MA 02112, telephone number (617) 426-3660.

This authorization shall be valid for 30 months from the date it is signed. I have read and I understand this authorization. I know I may request and receive a copy of it. A photocopy of this authorization is as valid as the original.

SIGNATURE OF INSURED
X | DATE SIGNED

NOTICE: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against the insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud. The commission of insurance fraud may subject such person to criminal and/or civil penalties. Any insurance company or agent of an insurance company who knowingly attempts to defraud a policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Division of Insurance.

ATTENDING PHYSICIAN'S STATEMENT

HISTORY

DATE ACCIDENT OCCURRED	DATE AMPUTATION OR LOSS OF SIGHT OCCURRED

LOCATION OF ACCIDENT (Work, etc.) DESCRIBE:

	Yes	No
Has patient ever had same or similar condition or prior disabilities?	☐	☐
At the time of the accident, amputation, or loss of sight, was the patient receiving care or treatment of any disease or illness?	☐	☐
Was the patient's dismemberment, total and irrevocable loss of sight caused (directly or indirectly) by any physical or mental infirmity; illness or disease; self-inflicted injury: commission of a felony; drugs or poison taken voluntarily; bacterial infection; travel on any military aircraft; or war?	☐	☐

If answers to any of the above questions "yes", describe particulars in detail, including dates.

DISMEMBERMENT

	Yes	No
Was there an amputation resulting in severance through or above the wrist or ankle joint? If "yes", give complete description of dismemberment.	☐	☐

TOTAL AND IRREVOCABLE LOSS OF SIGHT

	Yes	No
Did total and irrecoverable loss of sight occur as a result of the accident?	☐	☐
Did total and irrecoverable loss of sight occur more than 180 days after the accident?	☐	☐

WHAT WAS VISION AT LAST OBSERVATION? (SNELLEN NOTATION)

WITH GLASSES	O.D.	O.S.	DATE
WITHOUT GLASSES	O.D.	O.S.	DATE

DATE CORRECTED VISION WAS IRRECOVERABLY REDUCED TO 20/200 OR LESS IN THE BETTER EYE

MONTH/DAY/YEAR

☐ O.D. ☐ O.S.

VISION CAN BE RESTORED IN WHOLE OR IN PART BY:

O.D.	☐ LENSES	☐ TREATMENT	☐ OPERATION	☐ NOT RESTORABLE
O.S.	☐ LENSES	☐ TREATMENT	☐ OPERATION	☐ NOT RESTORABLE

Please enclose copies of any visual fields testing that has been done.

PLEASE INCLUDE COPIES OF YOUR MEDICAL RECORDS PERTAINING TO THE LOSS

NAME OF ATTENDING PHYSICIAN (Please print)	DEGREE	TELEPHONE NUMBER
		( )

PHYSICIAN'S ADDRESS (Street, City, State, Zip)

SIGNATURE OF ATTENDING PHYSICIAN	DATE SIGNED	PRINT NAME OF PERSON COMPLETING THIS FORM
X		

Minnesota Life
P.O. Box 64114
St. Paul, MN 55164-0114